The Repetition & Avoidance Quarterly

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Funding Changes Affect WDVA PTSD Contractors

Federal funding goes south as service demand heads north

As we lean steadily into the summer months of 2005, there seems to be no end to trouble and woe in the realm of war trauma treatment. At the center of these hardships is the federal VA funding shortages and staff hiring guidelines that are affecting staffing levels at the VA Medical Centers in Washington, Oregon, and elsewhere. These perfect-storm troubles are managing to strain the delivery of PTSD and mental health treatment throughout VISN 20. Other areas of the country are also affected, however it is well known that Washington State's veteran population, unlike other states, continues to grow. Greater demands on the military in Iraq and Afghanistan, as well as the increased combat roles of the Washington Army and Air National Guard (WAANG) and military reserves, have acted to raise the level of war and deployment related readjustment problems presented for treatment. Families are affected, forcing treatment entities to consider the wide ranging impact of the war on primary relationships and communities. In this period of Global War on Terror (GWOT), multiple deployments appear to be on the horizon for a long time to come. We may witness national guard and reserve units being sent to remote war zones for years to come. The accumulated stress and trauma of these repeat deployments, will no doubt add to the residual stress load for those deployed and family members.

State Funding Level Increases

Prior to the federal VA spending woes, planners at WDVA made a request of Governor Gregoire and the state legislature for additional PTSD Program funding. This money was to be used for those deployed Guard and reserves, and returning residences of Washington. The Governor responded with spending authority that met the request. The request however, was based upon the expectation that federal VA funding levels would be stable over the next two years. This assumption was applied especially in the community outpatient mental health area. Slippage in VA MH Fee Services funding however, has acted to force changes in the thinking about our state program spending strategy. OIF and OEF veterans, as well as current and new Vietnam veteran clients, have become the greater responsibility of WDVA. The actual rate of readjustment and PTSD diagnosis, as well as service demands of this war are still somewhat unclear, we do know that requests for re-adjustment counseling are significantly elevated. This includes another spike in the intake rate and case severity of Vietnam and other war veterans related to 911 and the current war.

Vendor rate increases—Slowly

The demand for more services comes at a time when our state-funded providers continue to labor under reimbursement rates that have remained lower than many other treatment support resources. Wit the regrettable changes in community treatment support from the VA, the need to raise reimbursement rates has become more evident in order to retain highly skilled treatment service providers.

Raising reimbursement rates is a double edged sword in that while it improves the fiscal stability of the providers, it also acts to limit the number of clients who can be seen with the same amount of money. This dynamic increases the need for programs and contractors to search everywhere for alternative funding to treat our state's war-affected veterans and family members. The WDVA PTSD Program has long been blessed by providers who freely give of their time and energy in the form of *pro bono* services. This, however, is not the way to operate a successful professional program in the long term—either voluntary *pro bono* services or of the type that creates "free services" when funding sources do not pay for needed care. This has unfortunately become the nature of the reimbursement landscape in recent years, placing huge demands on solo practitioners to track each treatment event carefully and compare this event to previous requests, authorizations, and payment. These demands force providers to seek professional accounting help, thereby driving up their costs of providing treatment. The private practitioner struggles to pay rent, insurance, CEU's, health care, and other benefits. Shifts in funding creates create a degree of panic for some, as they search for ways to find funding or amend the focus of their practice.

In this context, WDVA wants to thank our state's Vet Centers for working to increase funding to our mutual contractors. While this extra funding may last for only a few months, it does offer the extra support that some of our veterans require to maintain their gains with respect to their PTSD treatment.

Fall 2005 Educational Event

A Post-Deployment Conference will bring speakers and therapists together in Portland 3-5 November as VISN 20, RCS, and WDVA jointly organize a training designed to assist therapists who are treating OIF/OEF returnees. Emphasis will be the war's impact upon family and other significant relationships. More information will follow in the next *RAQ* edition about this upcoming conference.

(**Continued on page 6)**

Borderline Personality Disorder and Capacity to "Mentalize"

Glen Gabbard, M.D., of the Menninger Department of Psychiatry of Baylor Medical College, examined the psychotherapy process of borderline personality disorder in relation to the genesis of the disorder. He cites the traumatic background leading to a hemisperic lateralization of the brain in many persons with the disorder. Writing in the *American Journal of Psychiatry* ["Mind, Brain, and Personality Disorders," 2005, 162(4), 648-655], he states: "This failure of hemispheric integration may be reflected in the use of splitting as a major defense mechanism by borderline personality disorder patients. To deal with the concern that hate and aggression will destroy all positive qualities, they tend to compartmentalize self and object representations into 'all good' and 'all bad' categories" (p. 650).

Dr. Gabbard addresses the integral relation between "mind" and "brain" and speaks to the physical sequelae of early psychological trauma, particularly the hyperreactivity of the HPA axis and autonomic nervous system as a consequence of child abuse. He then speaks to the ability of psychotherapy to physically alter the brain, and addresses particularly the concept of "mentalization." He writes, "The capacity to mentalize, or have a 'theory of the mind' involves being able to recognize that someone else has a different mind from one's own..." (p. 651). He sees mentalization as being taught to the child through nurturing. "Mentalization is created in the context of secure attachment with a caregiver who ascribes mental states to the child, treats the child as a mental agent, and helps the child to create internal working models..." (p. 651). Dr. Gabbard notes that the absence of secure attachment causes children to fail to read their own mental states as well as those of others. "Early childhood trauma leads to a defensive withdrawal from the mental world on the part of the victim" (p. 651).

Dr. Gabbard gives a very nice example from his own experience as a psychotherapist working with a borderline patient in which she accuses him of wanting to get rid of her because he glances at his clock. He then becomes defensive and loses his own ability to mentalize. He writes, "One of the greatest challenges for a psychotherapist is managing this almost delusional conviction of some patients with borderline personality disorder that their perception is a direct reflection of reality rather than a *representation* of reality based on their internal beliefs, feelings, and past experiences" (p. 652). He asserts that the failure to mentalize makes it difficult for a patient to process transference, and when the therapist loses that ability, as he illustrates, one cannot think one's own thoughts in the therapeutic role.

Dr. Gabbard is an advocate of combining psychotropic medication, particularly SSRIs, with psychotherapy. He cites research that demonstrates that the additions of such medications reduces "affective noise" such as intense anger, hypervigilant anxiety and dysphoria, which, in turn, he suggests, will facilitate thinking and reflecting. As he states, "In the state of being terrorized, one cannot think clearly" (p. 653). The addition of SSRI medication allows the patient with borderline personality disorder to "more easily consider other motives in the therapist" (p. 653). He adds, "The patient can also have the luxury of reflecting on his or her own internal state. The patient can begin to see the therapist as someone there to help rather than persecute. Similarly, when the hypervigilant state in the patient is reduced, the therapist's capacity to think psychotherapeutically is less likely to be eroded" (p. 653).

Dr. Gabbard couches his discussion, which was presented originally in an award speech, in the context, as the title suggests, of the combination of genetics and environment in the development of personality disorder. He notes that the diathesis, or predisposition toward disease is usually influenced by environment and cites evidence from research on antisocial personality disorder. He presents an intriguing example in which researchers assigned a visiting home nurse randomly to high-risk new mothers. The visits started during pregnancy and continued through the child's second birthday. The control group consisted of mother-child pairs who received standard prenatal and well-child care in a public health clinic. The nurse visited the mothers nine times during pregnancy and 23 times after birth through the child's first two years. The nurse focused on health-related behaviors, competent care of children, and maternal personal development. Dr. Gabard writes: "At 15-year follow-up, adolescents born to women who had received the nurse visits had significanly lower rates of antisocial behavior, relative to the comparison subjects. They also had lower rates of substance abuse and fewer lifetime sex partners" (p. 650). He adds: "Results of this nature raise the possibility that early psychotherpeutic interventions might serve to influence the expression of genes that lead to antisocial behavior. A neglected benefit of individual psychotherapy is its positive effect on the *offspring* of the patient" (p. 650).

Comment

This reviewer hopes that the term "mentalize" never catches on. It seems to be an unnecessary addition to our overabundant collection of clinical/scientific jargon. However, Dr. Gabbard's endorsement of psychotherapy, and early intervention, is a valued addition. EE ##

A Guide to Understanding the VA's *Post-Deployment Handbook*—"Go Easy on Partying."

The federal Department of Veterans Affairs and the National Center for PTSD have published a *Post-Deployment Handbook*, designed to help veterans returning from war zones and their families adjust to the changes that have occurred. The sections has different authors, the first dealing with homecoming changes and expectations. The first statements are directed at soldiers and are remarkably understated: "You may miss the excitement of the deployment for a while." "Some things may have changed while you were gone."

To the spouse, it states: "Soldiers may have changed." It goes on to suggest some of the readily apparent changes, but then proceeds to describe children at various stages of development. "Teenagers (13-18 years) may be moody and may appear not to care." This appears to be a warning not to confuse normal development with the effects of deployment. This is important, because therapists have noted the problem of attribution among both professionals and non-professionals that tends to label behavior as being caused by PTSD. We see this when the veteran becomes angry and his spouse asks him if he's taken his medicine.

Non-sequiter

On page 4 of the handbook, author Julia M. Whealin, Ph.D, writes about what veterans need to know and gives us a whopper of a non-sequiter: "many military personnel will have experienced one or more traumatic events in their civilian lives." The sentence ends the opening paragraph, leaving the reader hanging with the question: So? What does it mean if a soldier going off to combat already has "experienced one or more traumatic events?" It is a statement that seems pregnant with important information, especially regarding the contamination of different trauma memories from different ages of development, which could lead to complex PTSD.

Handbooks are meant to be guides, but they are also by nature rather skeletal in structure. For instance, on page 5 the author advises the veteran to talk about his or her depression and suicidal feelings. "It is important to let others know about feelings of depression, and of course any suicidal thoughts and feelings…." This is a delicate matter, and we wish that the veteran be careful about choosing confidents.

Dr. Whealin gives sleep hygiene instructions on page 8. "Have a regular bedtime and rising time — Go to sleep and wake up at the same time every day." Or at least try. The author suggests that if the veteran doesn't feel safe in his or her bedroom, add some calming pictures, or a prayer. And what if that doesn't work? How about recognizing that feeling unsafe can be a memory stimulated by quiet?

Theory for Fact

On page 9, Dr. Whealin writes about dream theory as if it were fact. "They [dreams] are a way of working through a trauma." Psychodynamic theory asserts this, and it may be true, but it may also be true that dreams have nothing much to do with "working through a trauma." It is also theoretically sound to say that nightmares caused by trauma may be a neuronal misfiring cued by adrenalin, and not a "working through" at all.

Another example of theory passed on as fact is a bit of folk wisdom that Pamela Swales, Ph.D., shares on page 21, in the section on coping. She writes, "Get in the habit of using daily exercise as a friend. Exercise reduces body tension and helps get the 'anger out' in a positive and productive way." It is highly debatable that this is the case. One could certainly argue that exercise is an adrenalin *producer* and that the emotion of anger is independent of the process of exercise, except insofar as exercise tires one out and releases temporary calming endorphins. What Dr. Swales doesn't make a point of is the important distinction between the veteran respecting his or her anger while at the same time not acting it out.

Platitudes

In her "Tips to Soldiers" section of the PTSD Fact Sheet, Dr. Swales writes "Romantic conversation can lead to more enjoyable sex." To this she adds a bit of parental advice. "Make your savings last longer." Topped by another: "Go easy on partying." You who almost died, go easy on partying and save your money.

Numbers

The handbook gives the veterans and family members a wealth of phone numbers and web site addresses as resources for support, including the Washington State Department of Veterans Affairs 800 number and web site. Hopefully, those who seek counseling support will be receiving some more individually formulated advice.

We wish the handbook had been more, more realistic, more savvy, more convincing, but it will do. People who read it will pick out what they respond to. We wish these esteemed centers of learning had examined their platitudes and considered that they may sound hollow. They are the sort of platitudes one might expect to come from one's mother. In print, in an official document, they seem to be lines from someone who is of another generation and easily dismissed as unrealistic and inapplicable.

Here's hoping that you, reader, make your savings last longer. EE ##

Memory and PTSD: Forgetting May Be Protective

Israeli researchers have produced a valuable contribution to the understanding of PTSD. In a prospective study they have separated out the role played by the memory of a traumatic event in the genesis of PTSD. Sharon Gil, Ph.D., and associates of the Rambam Medical Center in Haifa published their results in an article in the *American Journal of Psychiatry* [2005, 162 (5), 963-969]. They examined and followed 120 head injured patients treated at Rambam, first assessing them within 24 hours after the injury, again in 7 to 10 days, 4 weeks, and 6 months. The assessments looked at the patient's recall of the event as well as psychopathology.

Dr. Gil and her associates addressed the assumption that lack of memory of a traumatic event serves as a protective factor against the development of PTSD. They also looked at whether memory of the event affected PTSD symptom clusters deferently. They found that at the end of six months 14% (17 of the 120 patients) had met the diagnostic criteria for PTSD. "Among the 55 participants with memory of the traumatic event, 13 (23%) had PTSD, whereas only four (6%) of the 65 participants without memory of the traumatic event developed PTSD. Thus, the crude relative risk for PTSD among the participants with memory of the traumatic event was almost five times higher than among those without memory of the traumatic event " (p. 966). Predictably, they found that the difference between the groups was found primarily in the reexperiencing symptom cluster.

Gil, et al., declared that "The central finding of our study is that memory of a traumatic event is positively associated with the risk for development of PTSD, while lack of memory of a traumatic event decreases the risk and might, in fact, play a protective role. Thus, along with other factors, such as history of previous trauma..., previous psychiatric morbidity..., and physical injury..., memory of a traumatic event appears to be another risk factor for PTSD. Moreover, memory of a traumatic event assessed as early as 24 hours posttrauma appears to be a strong predictor of PTSD at 6 months" (p. 967). The authors point out that their findings are restricted to head injury patients and thus are cautious about generalizing.

Gil, et al., add a note that highlights the importance of their research. "These findings seem to be in contrast with the theoretical assumptions underlying many of the therapeutic interventions with patients suffering from PTSD (e.g., exposure, abreaction, hypnosis) that highlight the importance of eliciting traumatic memories as part of the recovery process.... Our findings indicate that at least for traumatic brain injury survivors without memory of the traumatic event, forgetting may be protective, in which case the process of deliberate recollection and remembering may be harmful rather than therapeutic" (p. 967).

The authors call attention to the fact that their research also showed that 6% of the patients without declaritive memory also developed full PTSD, which indicates that the disorder is not dependent on declarative memory alone. Gil, et al., cautiously address the question that arises from their research, that memory disruption following a traumatic event may prevent PTSD. They point to the research recently conducted by Pitman and colleagues that administered propranolol selectively to accident victims found that subjects given the propranolol rather than placebo tended to show fewer PTS symptoms 10 days after the accident.

Gil, et al., discuss their research finding with an interesting point, that the memory of the traumatic event does not have to be accurate or even real. "Nevertheless, the finding that appraisal of memory of the traumatic event, regardless of its objective accuracy, appears to be a strong predictor of subsequent PTSD, is potentially important, and has both theoretical and clinical implications" (p. 968).

Dr. Gil and her associates at Rambam preface their article with a discussion of the different kinds of memory that highlights the important distinction between declaritive and implicit memory systems. "The intricate system of memory is commonly thought of as composed of two primary pathways. The first is referred to as explicit, or delarative, memory. This relates to conscious awareness of facts and requires focal attention for processing; it is probably mediated by the medial temporal lobe system that includes the hippocampal formation and related structures that enable verbal representation. The second pathway, referred to as implicit, or nondeclarative, memory, relates to memories acquired during skill learning, habit formation, and simple, classic conditioning. It also refers to other knowledge expressed through performance rather than recollection. These memories are believed to be less accessible to consciousness..." (p. 963).

Comment

As I understood it, the Pitman research referred to used propranolol not to block memory, but to block the adrenalin associated with the memory, thus, theoretically making it less salient.

Several therapeutic techniques involve processing traumatic memory: EMDR, systematic desensitization, the discussion of nightmares and intrusive memories, and even the popular cognitive therapies. I am reminded of the old adage, *Let sleeping dogs lie.* Applied here it means, if the memory is active and forcing itself into consciousness and influencing behavior, treat it as a therapeutic problem, but otherwise avoid psychotherapy techniques that seek to elicit memory of traumatic events. EE ##

Comorbid Chronic PTSD and The Treatment of Depression

Researchers from Harborview Medical Center and the University of Washington examined the implications of treating depression with comorbid posttraumatic stress disorder. Paul Holtzheimer III, MD, and colleagues compared short-term clinical outcomes for patients with depression with and without PTSD. The authors selected patients from a sample of 4,182 psychiatric admissions to Harborview over the course of five years from 1995 to 2000. From that group they compared 587 depressed patients with comorbid with PTSD with the same number of depresses patients without PTSD. Publishing their findings in the *American Journal of Psychiatry* (2005, 162(5), 970-976), Holtzheimer and associates matched patients in the two groups for demographic variables, including substance abuse, race, ethnicity, and gender. They write: "On admission, there were no differences between the two groups on clinical severity. However, at discharge the PTSD group had a significantly higher total score on the Psychiatric Symptom Assessment Scale and higher scores on the depression and hostility subscales than did patients without PTSD… (pp. 971-2). They add: "Length of hospitalization and the proportion of patients hospitalized involuntarily did not differ significantly between the groups…. However, likelihood of discharge against medical advice was significantly higher in the PTSD group…" (p. 972). The authors found that depressed patients with PTSD were more than 6 times as likely to be discharged against medical advice.

Holtzheimer, et al., expressed surprise that there was no significant differences in the two groups on the level of anxiety. They conjecture that the patients with PTSD in the sample mainly had chronic PTSD and were more likely to demonstrate avoidance and withdrawal, hence the higher rate of AMA discharges in the PTSD group.

The authors state: "Taken together, these results strongly suggest that for severely depressed patients, comorbid PTSD is associated with a poorer outcome during psychiatric hospitalization, including a greater likelihood for discharge against medical advice. This emphasizes the importance of recognizing PTSD comorbidity in such patients and raises the question of whether depressed patients with comorbid PTSD might benefit from more specialized treatment during psychiatric hospitalization" (p. 974). Holtzheimer, et al., point the way to the obvious next research effort, to explore whether treatment of chronic PTSD along with depression might improve treatment outcome for the patients with comorbid disorder. EE ##

Researching War Veterans' Histories

Just to pass on for those of you who are age-deprived, the senior journal, the *AARP Bulletin* ("Heirs of War," by Suzanne Freeman, May, 2005, pages 21-22) presents a guide to finding information about the service of World War II veterans. The author lists various books and web resources, which are replicated here.

www.loc.gov/vets "The veterans History Project is a Library of Congress oral history archive sponsored by AARP that provides tips for interviewing veterans."

http://members.aol.com/dadswar/index.htm "Dad's War links to many different groups with their own WWII stories."

www.fatherswar.org "The companion website to the book *Finding Your Father's War: A Practical Guide to Researching and Understanding Service in the World War II U.S. Army*, by Jonathan Gawne (2005).

My Father's War, by Julia Collins (2003).

Our Fathers' War: Growing Up in the Shadow of the Greatest Generation, by Tom Mathews (2005).

Our Mothers' War: American Women at Home and at the front During World War II, by Emily Yellin (2004).

The Souvenir: A Daughter Discovers Her Father's War, by Louise Steinman (2002).

Given the level of rich experience in this matter, contractors and counselors may have many more resources along the line of researching war records, and we urge readers to pass along that information to add to our store. EE ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email or write to WDVA.

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The Role of Cell Phones and Email and War Stress

In recent months several therapists have commented about the ready access that deployed military have to cell phones and Email within the war zone. Unimaginable in the days of Vietnam, we find today that soldiers often have their own cell phones or have ready access to Email links to family and friends back in the states—sometimes the moment of an attack, soon after an action, or during other stressful or dangerous engagements. The consequences of these rapid communication links is surely to be the topic of studies at some point. One can already see how the spouse of a soldier is affected when he/she is called just before the spouse or partner is headed out to a known hazardous duty. Or when daily contact suddenly falls off to no contact for days. The spouses that I have seen in this context seem to expect their deployed spouse to understand that in many ways, they were very close to the combat action in a vicarious, yet real-time, sense. Certainly, the worry and tension-relief cycles they experienced were very intense at times. It is my hope that other therapists consider writing an article here in the RAQ or elsewhere on this topic.

Washington National Guard and Reserve Drill Weekend

Within a few weeks there will be a new round of WA National Guard and military reserve drill weekend service events. Nearly 30 weekend events are scheduled that will provide service to unit members who want assistance with jobs, VA benefits, and referral for medical treatment and readjustment counseling. Coordinated under the guidelines of the Memorandum of Understanding signed earlier this year, many VA, Vet Center, and WDVA contractors are involved in these statewide events.

WDVA PTSD Contractor *Conference Call* Support System

In recent months I have enjoyed the opportunity of participating in a VA *conference call* network that offers support to therapists and program directors within VISN 20. This capability is present within the state phone system as well, and will soon offer WDVA PTSD Contractors another avenue for connection and support as they work with the many forces and treatment issues impacting their practice and personal lives. Our contractors know one another rather well from our annual conferences. Nevertheless, the conference calls will hopefully add depth to these already great working relationships.

Veteran Conservation Corps Set to Begin

About two years ago a chance meeting with State Senator Ken Jacobson, (D) Seattle, lead to an informal discussion about how things were going for Vietnam War veterans with PTSD and what we were expecting to see with the newest veterans coming home from OIF/OEF. The conversation was wide ranging, but the Senator picked up on my off-hand comment about a discussion I had with my neighbor, who is a biologist with the Department of Wildlife. That conversation related to alternative activities for combat veterans who suffer from PTSD and the work of salmon habitat restoration. The concept of veterans doing physical work out of doors, seemed to become caught in my mind. I had no idea that telling Senator Jacobson about it would result in the rest of this story.

At the opening of the last legislative session, Senator Jacobson called to ask, "Do you remember that conversation we had last year about salmon habitat restoration and veterans with PTSD?" He called it "your (my) idea," which frightened me a little, considering that I live in a town that does not always treat people well with new ideas involving money. He went on to say he knew a veteran (see Note below) who had done this work by himself for years, and that he (Sen. Jacobson) was working on bill language and wanted me to see it. Once completed, the bill was immediately co-sponsored by senators from around the state. Hearings were held as the bill threaded its way through committees and votes on the Senate floor. It passed with very strong support, then sailed through the state House of Representatives with bipartisan support.

Presently, I am organizing this new project ,which fits under the WDVA PTSD Program—*The Washington State Veterans Conversation Corps*. The initial task is to connect with the individuals in state government who manage dedicated state and federal funds for identifying and restoring the river, shoreline, and stream habitat of salmon. Since the ecology of salmon is closely linked to the health of other species, such as native oysters and clams, the new program will create work in various types of settings. So far I have learned that there are 50 to 60 contractors who bid on approximately $21,000,000 in habitat restoration contract dollars. These contractors are currently being asked if they would be interested in partnering with WDVA to offer war veterans with varying degrees of PTSD, an opportunity to work for pay in the habitat restoration field. WDVA will create a criteria for veteran inclusion on a list of names that will be provided to these contractors. Also, WDVA and the PTSD Program will provide consultation and training to these habitat contractors about the special work place and interpersonal needs of combat veterans with PTSD. The funding for this project will also allow me to hire a part-time contract employee who has demonstrated PTSD treatment skills, as well as a thorough working knowledge of biology and the habitat restoration industry.

The first year of this project will be a pilot as we shape the project and create ways of successfully involving veterans in the project. Initial goals are modest: Placement of 15 veterans with 3 of the restoration contractors throughout the state. This will allow us to learn about this process and make the necessary changes in the veteran selection and habitat restoration contractor selection process next year (2007). The project has an initial life through 2009, when we will be required to report our activities to the legislature. We are working closely with Senator Jacobson so as to capture fully the intent and outcome of this project. So far we have enjoyed widespread support for this effort, and believe it will enjoy wide spread support as a novel way of learning to live with and beyond PTSD and the trauma of war. All war era veterans are eligible for consideration. The work can be physically challenging but should be fulfilling.

NOTE: Hats off to John Beal of King County. John is a Vietnam veteran who has spent his life engaged in waterway restoration work. We will feature a story of John's successful habitat restoration work in a future *RAQ* edition. *TS ##*

Book Review:

A Vietnam Trilogy: Veterans and Post Traumatic Stress: 1968, 1989, 2000, by Raymond Monsour Scurfield

Reviewed by Emmett Early

There are a few people have experienced the Vietnam War and have an inside look at the Department of Veterans Affairs handling of the Vietnam War veteran. One of those few is Ray Scurfield, and reading his book is something of a history lesson, albeit from his personal point of view. Ray Scurfield served in Vietnam as a psychiatric social worker with officer status. He continued his social work profession after Vietnam by participating in many of the initial projects involved in treating the veterans for PTSD. Reading his book recalls some of the key names of the figures of this history, some famous, some infamous.

A Vietnam Trilogy is an autobiographical work of a man who, like Zelig and Forest Gump, managed to be a participant in important national policy-shaping events. He describes in his book the process and politics of selecting a research group to conduct the now much-referenced National Vietnam Veteran Readjustment Study (NVVRS). He writes: "Taken together, the NVVRS and [Vietnam veteran] twin study offer compelling scientific evidence that about one in every six Vietnam war veterans suffer substantial war-related psychological pain and impairment, and that exposure to combat significantly increased the risk of subsequently developing PTSD" (p. 3).

Ray Scurfield is critical of the politics both inside and outside the VA system that resisted the incorporation of effective treatment of PTSD for the war veterans. In a statement that this reviewer heartily agrees with, he writes: "There is a continuing collusion of silence and sanitization masking how much war harms those who participate in it. It appears that the government and society cannot admit the full reality and validity of both facts: that 'most' war veterans are doing fine, and that there is a significant minority who are not. Instead, efforts are still…[made] to minimize and discredit the war-related problems of those who have been troubled or conflicted during and/or after the war" (p. 5). He expresses similar sentiments talking about his work in Vietnam as a psychiatric social worker, addressing the policy of returning veterans to their units as soon as possible, and even rating the performance of the mental health personnel by how many were returned instead of evacuated. He addresses the double bind of risk of sending a psychiatric casualty back to his unit where he might be at risk, versus sending him out of country, where he runs the risk of "premature evacuation," and a life-long guilt.

Ray was involved in the negotiations at the Wadsworth VA in 1981 when a vet drove his jeep through the front entrance and shot up the place with his M-16. This led to a vets sit-in demanding policy changes. Ray expressed regret when he saw that after successfully defusing the sit-in confrontation, nothing really changed in the VA system. "Another disturbing thought that stayed with me over the years was that perhaps I had been an unwitting tool, co-opting the protesting veterans and evading the issues they raised. In other words, while I had contributed to bringing a peaceful resolution to the sit-in, at the same time I had contributed to breaking the momentum that had been building to address their concerns" (p. 72).

Ray mentions names that were involved in the lobbying of congress and the establishment of the Vet Center system. Having been part of the latter, some of the names evoke nostalgia of an electrifying time: Art Blank, Max Cleland, Ed Lord, John Wilson, Sarah Haley, to name a few. Ray describes the resistance within the VA system that we all felt who started up our local vet center. "I finally realized that the very top VA officials didn't want us to get the word out about the extent to which Vietnam vets were having war-related problems! This experience added to my growing realization about the pervasive collusion of sanitization and silence by a number of government officials since two World Wars, the Korean and Vietnam wars to suppress information about the extent of the long term negative impact of war on many veterans" (p. 86). (See this *RAQ*, p. 10, for a review of similar sentiment in *The War Complex.)*

Ray Scurfield ran a PTSD program at American Lake and then went to Hawaii to work in the VA system there. He finally left the VA system and is now an associate professor of social work at the University of Southern Mississippi. Some of his projects involving Vietnam War veterans have been sensational and regrettably involved television publicity. He took a group of veterans back to Vietnam in a project that led to some controversy. This was a therapy group and the trip understandably elicited strong and conflicting emotions. It was recorded and became part of a television program. Ray was also instrumental in taking vets with PTSD on helicopter rides, also captured on TV. Such work, being televised and broadcast to the general public, raises some very serious questions regarding the clients' right to privacy and the therapist's power to evoke voluntary participation. In light of recent research (e.g., see page 4 of this *RAQ)*, it is questionable whether such projects, which inevitably evoke both declarative and body memory, put the client at risk for worsening PTSD symptoms. This is particularly pertinent given that there is considerable media attention on the current war veterans, and reporters are seeking to record what goes on in the treatment groups.

To Ray's credit, he tackles another controversy head on, which involved our early PTSD program with WDVA. There was a contractor and several VA officials, Ray included, who participated in Native American ceremonies as part of treatment for PTSD. The objection expressed by Natives was that the use of parts of Native rituals was an affront and should not be conducted without full tribal authority.

(Continued on page 8, see *Scurfield.)*

***Scurfield*, Continued from page 7.**

In *A Vietnam Trilogy* Ray Scurfield provides an ample supply of vignettes and statements from Vietnam War veterans. Referring to the chronicity of PTSD, he gives us an example of a 94-year-old veteran who showed symptoms of PTSD from WWI. He noted (p. 203) that his "action" therapies served to increase veterans' self esteem, but outcome studies showed no change in their core PTSD symptoms.

Having such a unique position as an observer of a slice of history, Ray Scurfield provides us with a rich assortment close-up views. He observes that the compensation system renders service connected disabilities only on the basis of medical diagnoses. In a footnote (p. 208n), Ray is critical of a system that ties compensation to the diagnosis of PTSD and, he writes, forces a collusion between veteran and his or her treating mental health professional. "In other words, by long-standing governmental policies, a veteran must be considered "psychiatrically disordered" for there to be an official government recognition that he or she has been sorely impacted [b]y war duty and is 'deserving' of some financial compensation. But this is not all. Such a veteran also must engage in an on-going collusion with a VA mental health professional to downplay any significant progress in treatment or in one's condition" (p. 208n). Ray joins a chorus of critics who asserted, as he writes, that veterans are "forced to remain sick" and are penalized for reducing their symptoms. He calls it "a terrible conundrum" (p. 207).

A Vietnam Trilogy is valuable both as history and as a source of debate. He seems to lose a sense of intimacy that is found in clinical work in which the symptoms of PTSD are monitored and discussed. At the same time his broad perspective leads to a bit of romanticizing of the Vietnam War veteran as he concludes his book (p. 209), which may be the price one pays for writing such a career-long summary of mental health work.

Those of us who have been touched by the generational wave of the Vietnam War, sometimes likened to the passage of a pig through a python, have been altered by the experience. The value of *A Vietnam Trilogy* is that it illustrates the role of the government in addressing the long term costs of war. That for every soldier wounded in the field, mentally or physically, there are many others, including mental health professionals, who find their lives altered in dealing with the wounded veteran. It is not necessarily a positive alteration, but it is a reality. When the government pursues war, the wish is for the costs of past wars to go away, disappear. They never do, and we can't pretend otherwise. ##

Current War Casualties Threaten to Stress the Limits of VA Treatment

The Congressional newsletter *CQ Weekly* reported concern that the federal Department of Veterans Affairs medical facilities are not adequately funded to cope with the needs of returning war veterans and maintain commitments to the veterans of other wars. *CQ* staff writer, Tim Sparks, [May 23, 2005, p. 1362], writes: "The Department of Veterans Affairs is already beginning to feel the pressure for more services at a time when its medical caseload is rising anyway. Of the approximately 300,000 soldiers who have left active duty after service in Iraq or Afghanistan, more than 63,000 have sought health care from the VA. With the end of combat nowhere in sight, those numbers will undoubtedly rise."

Mr. Weeks cited the increasing ability of the U.S. military to evacuate the wounded and prevent death. "During the Civil War, fully half of those injured in battle soon died of their wounds. By the Vietnam War, the mortality rate from wounds was down to 25 percent, thanks to such advances as helicopter evacuations. Now, according to government statistics, fewer than 10 percent are dying of their wounds. Doctors say that if casualties can be reached on the field, fewer than 5 percent are lost." Mr. Weeks adds, "Any soldier too sick to return to duty in 72 hours regardless of the cause, is flown out of Iraq and Afghanistan for treatment…."

Mr. Weeks cited data indicating a high rate of survival is attributed to body armor that also leads to traumatic amputations (400 so far) and brain damage (some 60 percent of wounded). He also notes that PTSD and traumatic brain injury make recovery from other wounds more difficult. The *CQ* reporter referred to the *New England Journal of Medicine* (July, 2004) article that found that "more than 6,000 troops, nearly one in five was leaving the war with … (PTSD) and other mental health problems." The author speculated that the nature of the urban warfare against irregular forces creates more cues and triggers for veterans after they return home. He added: "Through Feb. 11 of this year, according to the VA, 17,214 Iraq and Afghanistan veterans had been diagnosed with mental disorders, about 27 percent of the total."

Comment

Mr. Weeks quoted veterans' advocates as expressing fear that the underfunding of the veteran side of the war effort will lead to the neglect of services to the aging veteran population. Such evidence has already been seen locally in Western Washington as news was dispatched by a VA Fee Services spokesperson that Fee Service treatment of PTSD would be stopped and veterans receiving psychotherapy in the community would be required to come to the VA hospital for their care. After that, however, inevitable ambiguity set in and what seemed frozen turned to slush, and no clear policy has been articulated by the Department of Veterans Affairs. EE ##

Book Review:

Rules for Old Men Waiting, by Peter Pouncey

Reviewed by Emmett Early

I just finished a book that I recommend to anyone who works with war veterans. It is a recently published first novel by Peter Pouncey, an Oxford educated classical scholar and educator. It concerns war veterans of several wars in multiple layers of meaning. The story concerns Scotsman Robert Mac - Iver, whose aviator father died in World War I, who himself was a British navy veteran of World War II, who made a career as an historian collecting oral histories of gas victims of World War I. The novel takes place as MacIver, an old man, is dying. His wife has passed before him, his son before them. Their son, David, dropped out of Yale and enlisted in the army during the Vietnam War, requesting a medic MOS and volunteering for Vietnam. MacIver is striving to finish a story about British soldiers in World War I. What sickness is causing his decline is unspecified, except for symptoms of nausea, pain, and loss of concentration.

MacIver's story concerns the deadly dynamics of British soldiers in the trenches: a hardened sergeant who goes into no-man's land at night seeking trophies, a courageous lieutenant, and an artist-soldier who sketches the scenes in the trenches. The beauty of Peter Pouncey's accomplishment is the subtle interweaving of the stories, with the orientation always on the dying man and his rich and rewarding memories of his wife, an artist/illustrator of some accomplishment. MacIver, isolated in his rural home, struggles to eat and care for himself. His memories are so rich that his struggle never seems self pitying or morbid. He is still creating and his memories of his wife, his rugby, his war, of his son, enrich the story. MacIver is a legend as a college rugby player. He is a tough old professor who was chided by his dean for abusing his students and any colleagues nearby with his vicious acerbic wit after his son died of complications following the amputation of his leg in Vietnam. MacIver's rage is never focused on the war or the politics, but seems fueled by his agitated depression.

MacIver has published one successful book, *Voices Through the Smoke*, that compiles his oral history of the gas victims of World War I. As he is struggling with his agitated grief in the wake of his son's death, he seeks out a psychiatrist, who has agreed to see him on his condition that she only prescribe and not try to do talk therapy. She happens to be a collector of his late wife's art, and knowledgeable of his work. She says, "'In college my history professor had us all read *Voices Through the Smoke* for our course on the twentieth century, "Death of Victoria to Victory over Japan."' She was both charmingly embarrassed and amused at herself at the same time. 'He said, I remember, it was the first book of history to display the horrors of war extended indefinitely forward in individual lives with the sustained force of a poetic image.'"

The Grief of History

Peter Pouncey knows depression. I found his description of the disorder, prolonged grief following the death of his son in a veteran's hospital fresh and interesting.

"Not today. Today a quiet one of harboring diminishing resources for future frays. You know, the cruel thing about depression is not that it makes you see the world darkly. How else should one look at the bloody thing? The real debasing role of depression is to remove all flashes of energy or concentration, to ensure that you can never complete anything. Depression as depth fatigue. It takes a particular zest in grinding you to immobility, so that you have no smidgeon of self-esteem left. It's my kind of guy—no half-measures, takes no prisoners" (p. 142).

Rules for Old Men Waiting is an exquisite work of fiction that incorporates in smooth fashion the viciousness of prolonged warfare, the value of having served one's country in the military service, the tragedy of the loss of one's son, the grief at the loss of one's 35-year loving relationship, and the character of a man dying who has been vigorous and tough and artistic with his anger.

The Artist and the Warrior

The struggle between the artist, the artistic sentiment, and the warrior, the spirit of aggression, plays out on one layer between MacIver and his wife, Margaret, and on another layer, between MacIver's creations, the brutal sergeant in the trenches and the young private, the artist, and then, again, the struggle is embodied in MacIver's son, David, who is so touched by a fireman performing an heroic rescue that he volunteers for Vietnam, leaving his student life at Yale. All of which is encapsulated in the doctor's description of MacIver's work: "it was the first book of history to display the horrors of war extended indefinitely forward in individual lives with the sustained force of a poetic image."

As psychotherapists for war veterans and their families we are the witnesses of "the horrors of war extended indefinitely forward in individual lives." Like MacIver to his son, David, volunteering for Vietnam, we view our clients with a mix of pride and sadness, and we are left with the empty helplessness as we witness that war repeats, and repeats, and repeats as we pass on, and there is no stopping the process, yet there is no ignoring it, either. ##

Book Review:

The War Complex: World War II in Our Time

By Marianna Torgovnick

Reviewed by Emmett Early

The ways in which I, born in 1939, could describe how World War II influenced me are uncountable. I can remember, or think I can, the air raid warden sticking his head into our window to tell us to cover our radio dial. I think I can remember my Uncle Cece coming to tell us that Pearl Harbor had been bombed. I lived in former WWII shipyard workers housing. During the Korean War I fought in forests and canyons using dirt clods for hand grenades, two-by-fours for burp guns, with nails for triggers. I watched *Victory at Sea* on the neighbor's black and white TV, read their picture books of WWII air wars. I grew up in the fear of nuclear holocaust launched by Soviet flying Bears (they had a bomber called the Bear). I joined the air force in advance the draft and watched on TV the great international Cold War confrontations of the early 60s as SAC bombers left contrails overhead.

Marianna Torgovnick wrote a curious long essay from Manhattan as the Twin Towers were destroyed. She wrote about the influence of war, especially World War II, on our world today in a way that demands our attention. In *The War Complex* she examines several war-related catastrophes and speculates about their relative absence from our collective awareness. Although she frequently quotes from Freud, she isn't quite able to help us understand the implications of that influence. She looks particularly at the regard we have for the Allied victory in Europe and compares it to the obscurity of the Pacific War. She looks at the Allied fire bombing of German and Japanese cities, not so much taking issue with their military value, but the way in which the U.S. culture is ignoring the facts. She looks at the A-bombing of Hiroshima and Nagasaki with similar curiosity, asserting that we have culturally cut them out of our consciousness.

Ms Torgovnick is a professor of English at Duke University and, as she writes, has married into a Jewish family and took up role as a curious observer of the long term impact of the Holocaust on proceeding generations. She writes, "the war complex is the difficulty of confronting the fact of mass, sometimes simultaneous, death caused by human beings wielding technology, in shorter and shorter periods of time, often on religious or ethnic grounds and under government or other political auspices--a fact urged upon us repeatedly by World War II but as insistently deflected" (p. 143). She makes frequent reference to the fact that we can ignore facts that are right in front of us because of various motives. She suggests that these examples of mass death will affect the post-war culture and, as with individual consciousness, the effect will be unconscious if the facts are buried.

Ms Torgovnick's thesis is important because it highlights how undesirable facts about war are, not so much repressed as collectively ignored. The fire bombings of civilian populations, for example, may have been carried out as much for revenge as for tactical value. The war in Europe, particularly the Normandy invasion, and more particularly the U.S. efforts at Omaha Beach, have become emblematic of the whole war effort, while, she points out, other battles were far more costly in terms of human life. That the bombings were carried out in revenge for German fire bombings of English cities, perhaps too for the Holocaust, places a more malicious shadow over U.S. *Saving Private Ryan* nobility.

The author observed the important fact that the Soviet Union lost somewhere between 20 and 50 million dead in World War II. This fact was largely ignored in the Cold War culture while we lived instead in a collective kind of paranoia that the devastating effect of technology was about to strike from the frozen reaches of the Siberian wasteland. She observed that Allied offensive slowed as it reached Germany, leaving the most brutal fighting for Berlin to take place between the German and the Soviet forces.

Ms Torgovnick begins her book with a description of the impact the 9/11 terrorist attacks had on her and her neighborhood, a few blocks from Ground Zero. She proceeds then to describe the collective reaction, the labeling of all the victims as heroes and the unquestioned patriotic fervor that led to the sprouting of flags and the passage of bills that compromised some of the very freedoms we imagined defending. Her point is that the impact of that horrendous act of war will play out in significant ways in our culture, leading to invasions of other countries, acts of wartime urgency and permissiveness that assume a righteousness that is unquestioned.

Are the devastations that warfare create justified by what went on before? The author asks us to wonder about what the massive killings, and our collective ability to ignore the facts that are yet available to us, do to our decisions. The noble, white knight romance of defending freedom and democracy at any cost may be the offspring of not being able to see our own shadow. Cultural memory, she points out, prefers to avoid ambiguities. Clarity comes from narrowing the focus and leaving out peripheral distractions.

We who treat war veterans in psychotherapy get to witness the anger of former combatants who are only partly angry at the conditioning of warfare, more likely to be angry that they witnessed the ambiguity of what the enemy represented and the victory that cost so many innocent lives. ##

Movie Review

The Big Red One: The Reconstruction

Reviewed by Emmett Early

Samuel Fuller was a movie director who is still held in high esteem after his death in 1997. I admire him for the fact that he volunteered for the army and for infantry at the outbreak of World War II at the advanced age of 29. I conjecture that he may already have been traumatized by witnessing electric chair executions as a newspaper reporter, events he had nightmares about to the end of his life. He served in the Big Red One, the First Infantry Division, from the start of the North African campaign in 1942. He fought in Sicily and he was part of the Normandy D-Day landing. He fought in Belgium and in the Battle of the Bulge, and was part of the liberation of the Falkenau concentration camp in Czechoslovakia in 1945. He returned to direct movies for Hollywood and wrote several scripts for his movie about the Big Red One. Studios wouldn't fund it without a star, like John Wayne, but Fuller refused to do the film with Wayne, because he *was* a star. These facts and more can be found in his wonderful 2002 autobiography *A Third Face.*

Fuller was finally able to make the movie, but *The Big Red One* was released in 1980 drastically truncated, creating a legend among film cognoscenti that a three hour version had been salvaged from the cutting room floor. The film was found and legend was made real when *The Big Red One* was reconstructed and a two-disc set was released in 2004, with commentary by many of the principle actors and the film scholar, Richard Schickel, who led the reconstruction work.

Those of us who were disappointed by the drastic cut in the studio release can be mollified by the reconstructed version. Although the film was made on a skinflint budget, the reconstruction gives us a Samuel Fuller-eye-view of the war. Fuller collaborated with actor Lee Marvin, a marine veteran of the Pacific war, and together they created the man with no name, called "The Sergeant." The film begins on the final day of World War One, with the symbol of the war-devastated landscape, marked by a large cross depicting the crucifixion of Christ still standing. The Sergeant kills a German trying to surrender. The war has ended, the German soldier knew, but Sarge didn't. Fuller sets the opening scene with the statement: "This is a fictional life based on factual death."

The Sergeant then appears preparing green troops for the U.S. invasion of North Africa in 1942, wearing on his sleeve the Big Red One insignia, which he had taken as a prize from the dead German soldier. Fuller plays craggy, old Lee Marvin's Sarge off against the green recruits. Even as the solders are exposed to combat time after time, as they also become hardened, they continue to play as youthful contrast to the older generation war veteran.

Fuller develops the theme juxtaposing the painful experience of combat, repeated combat, and the innocence of children. Through every campaign, a native child forms a relationship with The Sergeant. He attempts to ignore them, but they persist in hanging around him. There is a long haired Arab boy in North Africa. A pre-adolescent girl in Sicily decorates his helmet with flowers at a festival to celebrate the defeat of the Germans. They come upon a filthy boy leading a donkey cart with the stinking corpse of his mother in it. He agrees to show the squad where a German gun is located that has been harassing advancing U.S. troops if they will help him bury his mother. In Czechoslovakia, Sarge picks up a starved, mute boy and carries him, trying to feed him until it appears that the boy dies.

At the end of the film, Sarge again attempts to kill a German soldier trying to surrender. This time his squad bring him the news that the war in Europe is over. They discover that the German soldier is still alive and Sarge endeavors to apply first aid to the wounded man.

There is, during the scenes in Belgium, a passage that reminds this viewer of the British film, *King of Hearts*. Here the squad are assigned to search out a German observation post that is located in a monastery-turned mental hospital. There is a red-headed woman there posing as patient, who is a member of the underground resistance. She dances around among the German soldiers, who think her attractive but mad, slitting their throats. When the squad enters and starts shooting, the patients all act like catatonics, oblivious of the gunfire, except for one patient who picks up a submachine gun and blasts away randomly.

Reconstructed or not, *The Big Red One* is vast and episodic. Some of the values are dated. The one young trooper who is a wise guy writer, taking part of Fuller's character, chomps a cigar through the film, even sloshing through the bloody waves at Normandy beach. Yet the film also has the integrity of having been written and directed by a combat veteran. It seems true when the survivors of one battle refuse to befriend the replacements. When one baby-faced replacement asks why the cold shoulder, the veteran tells him that new guys are likely to be killed. And when the new guy asks if he thinks he'll die, the veteran replies: "You ain't special."

Fuller himself appears in the film after the war has ended and the occupiers are mingling with the civilians. Gray-haired and wizened, he poses as an army film cameraman taking pictures, mainly of the children. "It's about survivors," someone remarks at the end. ##

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King County Veterans Program, also provides vocational counseling , jail diversion, and emergency financial assistance, and is located at 123 Third Ave. South, Seattle, WA. 206 296 7656.

The King County Veterans Program works under contract with WDVA PTSD Program to provide counseling and evaluation services to veterans.

To be considered for service by a WDVA or King County PTSD Contractor, a veteran or veteran's family member must present a copy of the veteran's discharge Form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used to prove the veteran's military service. You are encouraged to call Tom Schumacher for additional information.

It is always preferred that the referring person first telephone the contractor to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning or referral alternatives.

Many of the PTSD Program contractors conduct both group and individual/family counseling. ##

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